2746 **By Exam**
$125.00
$ 75.00
$ 10.00
$210.00

BOARD OF SOCIAL WORKER CERTIFICATION AND LICENSURE
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243
(615) 532-5088, or (800) 778-4123 ext. 25088
www.tennessee.gov/health

APPLICATION FOR LICENSE BY EXAMINATION AS A CLINICAL SOCIAL WORKER

INSTRUCTIONS

1. Complete this application, have it notarized, enclose a non-refundable check for $210 payable to the Board of Social Worker Certification and Licensure, and mail it to the above address. Please type or print legibly.
2. Attach one (1) "passport" style photograph to the front of this application. Be sure to sign the photograph on the back.
3. Attach a photocopy of your college diploma or transcript and have an official transcript sent directly from your school to the above address.
4. **All applicants applying for LCSW by examination should enclose records/logs of the 100 hours of supervision conducted by an LCSW and the supervisor(s) should submit the 100 hour log as well. Records/logs of the two thousand (2000) hours of clinical experience should be submitted by the applicant, but maintained by both. YOUR FILE WILL NOT BE COMPLETE WITHOUT THEM. SAMPLES OF LOGS ARE ATTACHED, BUT THE FORMAT IS NOT MANDATORY.**
5. If you have ever been licensed or certified in another state, complete page 9 and follow instructions.
6. If you have already passed the ASWB clinical exam, please have your scores sent directly from the ASWB to the above address.
7. If you have not already passed the ASWB clinical exam, please register with the testing agency only after the board has sent you written notification of your eligibility
8. Criminal Background check required as of June 1, 2006 **click here** for instructions.

NAME _____
First Middle and/or Maiden Last

DATE OF BIRTH _____ SOCIAL SECURITY # _____

CURRENT HOME MAILING ADDRESS:

_____

_____

_____

CURRENT PRACTICE ADDRESS:

_____

_____

_____

HOME PHONE # _____ WORK PHONE # _____

HOME E-MAIL ADDRESS _____ WORK E-MAIL ADDRESS _____

List all states where you currently have or have ever had licensure or certification to practice as a social worker.

_____ _____ _____ _____ _____

CLINICAL SUPERVISION HISTORY

Instructions: The Professional Reference Assessment on pages 6 through 8 must be submitted for each supervisor recorded on this page.

Previous Employment

Supervisor's Name: _____

Supervisor's Degree: _____

Employment Dates: From ____-____-____ to ____-____-____

Total weekly non-clinical hours _____
Total weekly client-therapist hours _____
Total weekly group supervisor-supervisee hours _____
Total weekly supervisor-supervisee hours _____
Total weekly employment hours _____
Total client-therapist hours during supervision period _____
Total supervisor-supervisee hours during supervision period _____
Total group-supervisor supervisee hours during supervision period _____
Total number hours of supervision

Previous Employment

Supervisor's Name: _____

Supervisor's Degree: _____

Employment Dates: From ____-____-____ to ____-____-____

Total weekly non-clinical hours _____
Total weekly client-therapist hours _____
Total weekly group supervisor-supervisee hours _____
Total weekly supervisor-supervisee hours _____
Total weekly employment hours _____
Total client-therapist hours during supervision period _____
Total supervisor-supervisee hours during supervision period _____
Total group-supervisor supervisee hours during supervision period _____
Total number hours of supervision

_____ _____

Applicant's Name Social Security Number

This Page May Be Duplicated

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the affirmative, attach an explanation on a separate sheet. In support of your explanation the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application. For the purpose of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice as a Clinical Social Worker"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate diagnosis or evaluation, and exercise reasoned judgment, to learn, and keep abreast of development in the field of social work.

   b. The ability to communicate those judgments and information to clients and other health care providers, with or without the use of aids or devices, such as voice amplifiers.

   c. The physical capability to perform tasks and procedures required or your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological disorders, such as, but not limited to: orthopedic, visual, speech and/or hearing impairment, cerebral palsy, epilepsy, muscular dystrophy, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

3. **"Chemical Substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

5. **"Illegal Use of Controlled Substances"** means the use of controlled substances obtained illegally (e.g., heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS	YES	NO
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice as a Social Worker with reasonable skill and safety?	_____	_____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	_____	_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner, in which you have chosen to practice?	_____	_____
(If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether conditions should be imposed, or whether you are not eligible for licensure.)	_____	_____
2. Do you currently use chemical substances?	_____	_____
If yes, do they in any way limit your ability to practice as a Social Worker with reasonable skill and safety?	_____	_____
3. Are you currently engaged in the illegal use of controlled substances?	_____	_____
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaged in illegal use of controlled substances?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	_____	_____
5. If you have ever held or applied for a license or certificate to practice as a Social Worker or as any other health care professional in any state, county, or province, was or has it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

QUESTIONS	YES	NO
6. If you have ever had staff privileges at any hospital or health care facility, have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	_____	_____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8. Have you ever been rejected or censured by a Professional Association?	_____	_____
9. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered against you?	_____	_____
b. Have you ever had settlement of any legal action rendered against you?	_____	_____
c. Are there any legal actions pending against you or to which you are a party?	_____	_____

AFFIDAVIT, CONSENT, AND RELEASE OF APPLICANT

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying statements and transcripts are true, complete, and correct. I understand that any false or misleading information in or in connection with my application may be cause for denial or loss of my license.

I further swear that I have read and understand the statues and the Rules and Regulations regarding the practice of my profession, which are posted on the board's internet site and/or were provided to me by the board office, and agree to abide by them while licensed by Tennessee.

I also authorize the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competency, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

CONSENT TO THE RELEASE of such information.

RELEASE FROM LIABILITY the board, its staff, and all their representatives for their acts performed and statements made in good faith and without malice in connection with evaluation of my application, my credentials, and my qualification.

I hereby authorize release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

ACKNOWLEDGE THAT I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubt about such qualifications.

_____
Signature of Applicant

Sworn to and subscribed before me this _____ day of _____, _____.

Commission Expires: _____ _____
(Date) (Notary Public)

Notary Seal

REFERENCE FORM LETTER

Applicant's Name _____ Social Security Number _____

I hereby certify that _____ has had the equivalency of two (2) years' full-time clinical experience under the supervision of a licensed clinical social worker (2,000 clinical hours in not less than a two-year period with a minimum equivalency of one hour per week supervision).

Employment information regarding the applicant follows:

Place of Employment	Dates of Employment	Name and Degree of Supervisor

_____
Signature
Licensed Clinical Social Worker*

License Number _____ State _____

Sworn to and subscribed before me this _____ day of _____, _____.

_____
Signature of Notary Public

(Notary Seal)

My commission expires _____

Please return to:

Board of Social Worker Certification and Licensure
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

***This letter must be signed by an LCSW who did not provide the applicant's supervision. If the signator is not licensed in Tennessee, enclose documentation of the other state license.**

PROFESSIONAL REFERENCE ASSESSMENT
(Verification of Supervision)

THIS SECTION TO BE FILLED OUT BY APPLICANT:

Applicant's Name _____ Social Security Number _____

I have applied to the Tennessee Board of Social Worker Certification and Licensure to become a licensed clinical social worker. Your assessment of my characteristics will enable the board to evaluate whether I meet their standards.

Signature _____ Date _____

REMAINDER OF THIS FORM TO BE FILLED OUT BY SUPERVISOR (TYPE ALL INFORMATION).

1. Supervisor's Name: _____

Profession: _____ Educational Degree(s): _____

Business address (street/city/state/zip): _____

_____

Position Title: _____ Telephone: (_____) _____

2. Supervisor's License No.: _____ Licensing State: _____

Date Licensed: _____

Clinical experience: Yes ___ No ___ Number of years: _____

3. Recordkeeping: Dates of Supervision: from _____ to _____
(month/year) (month/year)

Total number of months of supervision _____
Total weekly client-therapist hours _____
Total weekly supervisor-supervisee hours _____
Total weekly group supervisee-supervisor hours _____

1. Total client-therapist hours during supervision period _____
2. Total supervisor-supervisee hours during supervision period _____
3. Total group supervisee-supervisor hours during supervision period _____

Total number hours of supervision _____
(Add #2 and #3)

4. Nature of setting in which supervised practice took place:

5. Please rate the applicant on the following characteristics. Place a check mark in every category!

Characteristics	Outstanding	Above Average	Average	Below Average	Can Not Evaluate
Individual counseling skills					
Appropriate referral making					
Group counseling skills					
Personal integrity					
Consulting skills					
Insight into client's problems					
Ability to relate to co-workers					
Ability to be objective on the job					
Ethical conduct					
Concern for welfare of clients					
Sense of responsibility					
Recognition of own limits					
Supervisory abilities					
Ability to keep material confidential					

6. Explain any rating of below average, poor, or can not evaluate (use additional paper if necessary).

I certify that the information contained herein is an accurate account of my supervision of

Applicant's Name) _____

_____ _____

Supervisor's Signature Date

Subscribed and sworn to before me this _____ day of _____, _____.

SEAL

Notary Public _____

My commission expires on the _____ day of _____, _____.

Return completed form to:

Board of Social Worker Certification and Licensure
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

This Form May Be Duplicated.

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243

TENNESSEE BOARD OF SOCIAL WORKER CERTIFICATION AND LICENSURE

Please complete the top portion and mail this form to the regulatory board in each state where you hold or have held a license or certificate to practice as a Social Worker. (If additional forms are required, this form may be duplicated.) Please disregard this page if you are not licensed or certified or have never been licensed or certified as a social worker in another state.

NOTE: Some states require a fee for providing verification information. In order to expedite your application, you may wish to contact the applicable state or states.

****

I was granted _____ on _____ by the State of _____
(License #) (Date)

The Tennessee Board of Social Worker Certification and Licensure requests that I submit evidence that my license or certificate in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Social Worker Certification and Licensure.

Date: _____ Signature: _____

SSN#: _____ Printed Name: _____

****

THIS PORTION IS TO BE COMPLETED BY STATE LICENSING BOARD

License Number: _____ Date Issued: _____

Basis of Issuance: Endorsement/Reciprocity With: _____

Written Examination: AASSWB CLINICAL _____ STATE _____ OTHER _____ DATE _____

Raw Score _____ Scale Score _____ Corrected Score _____

Percent Score _____ Standard Deviation _____ National Mean _____

License currently registered: _____ Yes _____ No

Derogatory Information on File: _____ Yes _____ No
If "yes", please attach explanation.

_____
Authorized Signature

_____ State Seal
Title

_____
Date

Contract for Clinical Supervision

(Supervisee must obtain CMSW prior to supervision process if application for LCSW is desired)

Supervisor: _____	**Supervisee:** _____
LCSW# _____	***CMSW#** _____
Type of Supervision: Indv. - _____ Group	**Date:** _____

This agreement for clinical supervision is formulated based on the models provided by the National Association of Social Workers in "Guidelines for Clinical Social Work Supervision" August 1994 edition prepared by NASW National Council on the Practice of Clinical Social Work & requirements of the Tennessee Division of Health Related Boards, law and regulations promulgated under TCA 63:1-101 through 63:1-138 inclusive, and including the General Rules and Regulations of the Tennessee State Board of Social Workers Certification and Licensure Chapter 1365-1-101 through 1365-1-19, inclusive. General content is to improve professional performance of supervisee & to satisfy requirements of above named Health Related Board requirements toward the Licensed Clinical Social Worker (LCSW) credential.

Responsibilities:
Both supervisee and supervisor are responsible for maintaining the terms within this contract and for the ongoing integrity of the supervisory sessions ad overall process.

Method of Supervision:
Supervisory session will include presentation of case material, discussion and feedback, demonstration of skill through written recording format, skills regarding diagnosis & assessment, theory, technique, ethics, self-analysis, termination, documentation, social work laws/regulations & agency administration.

Documentation:
The supervisee will have primary responsibility for documentation of supervisory meetings. Supervisor will maintain record of frequency of supervisory meetings.

Format:
Supervisory meetings will be frequent & regularly scheduled. At least one hour of supervision will be provided per 20 hours of clinical contact, for a total of at least 100 hours of supervision (applying to at least 2000 clinical contact hours) over no less than a two-year period.

Learning goals/objectives of supervisory process:

1. Ongoing assessment of supervisee's strengths and limitations in accordance with sound theory/practice; NASW Code of Ethics; & legal and administrative regulations.
2. Development of clinical assessment/treatment skills, & therapeutic techniques as related to specific cases.
3. Exploration of treatment options to include community resources.
4. Discussion regarding dilemmas created by conflicting demands of client needs, ethical responsibilities, agency requirements and resource availability.
5. Planning around career and general professional development issues.
6. Examination and self-analysis regarding treatment skills/techniques.

Evaluation and accountability:
Supervisor assumes professional liability for client contact activities of supervisee while contracted relationship exists. Supervisor is expected to prepare evaluations, recommend for licensure or refuse to recommend for licensure or take any other actions that may be necessary within the scope of the supervisory relationship and in keeping with the professions' ethical standards. Evaluation of the supervisee's performance is understood to be an ongoing process, with periodic evaluations occurring on a regular basis (suggest 3 month intervals), in format to be determined by both parties.

SIGNATURES:

_____ _____

(Supervisor) (Date) (Supervisee) (Date)

Summary Statement of Supervision

Supervisor: _____ **Supervisee** _____
LCSW # _____ **CMSW #** _____

This statement is prepared for the purpose of briefly describing the contract, record, and manner of supervisory *sessions* ***(Insert name of LCSW)*** conducted with ***(Insert name of CMSW)*** as part of the preparation and requirements for the LCSW credential. Reviewers are also requested to refer to three documents attached:
(1) Contract for Clinical Supervision, (2) Supervision Log and (3) Summary Record of Supervision.

Sample:

I confirm that the supervisory sessions were conducted in accordance with the agreement for clinical supervision that ***(Insert name of CMSW*** and ***(Insert name of LCSW)*** developed at the beginning of ***Insert total # of hours*** of direct, face-to-face supervision. Over this time period, …***(provide a description of what occurred i.e. focus on therapeutic intervention, direction, interventions, topics, etc.)***

Note: Include discussion regarding level at which supervisee utilized supervisory sessions, perceived abilities and recommendations regarding entrance to sit for LCSW exam.

SIGNATURES:

_____ _____
(Supervisor) (Date) (Supervisee) (Date)

NOTARIZATION: (Optional)

_____ _____
(Notary signature) (Date) (Notary number) (Date)

Appendix C

Summary Record of Supervision

Supervisor: _____ Supervisee _____
LCSW #_____ CMSW # _____
Beginning Date: _____ Ending Date: _____

DATE	TYPE OF SUPERVISION	HOURS
Example		
12-21-2000	Individual	1
12-28-2000	Group	1
01-14-2001	Individual	1
01-21-2001	Individual	1
01-28-2001	Individual	1
02-04-2001	Individual	1
02-11-2001	Individual	1
Vacation Week		0
02-25-2001	Individual	1
03-04-2001	Group	1
03-11-2001	Individual	1

Total Hours _____ 10 ____ (8 Indv/2 Group)

(Note) Use new sheet for each supervisor

I testify that the supervision record described above is accurate.

SIGNATURES:

_____ _____
(Supervisor) (Date) (Supervisee) (Date)

NOTARIZATION: (Optional)

_____ _____
(Notary signature) (Date) (Notary number) (Date)

Note: Health Related Board regulations mandate that supervision occur in one hour segments and are conducted face-to-face. It further mandates that a minimum of 60% of supervision hours must be completed as individual and a maximum of 40% of supervision hours may be completed as group. 100% can be completed as individual however.

Supervisee Log

Supervisee _____ Subject of Supervision Session
CMSW # _____ (Mark all that are applicable)
Supervisor _____ ___ Ethics ___ Boundaries
LCSW # _____ ___ Theory ___ Technique
___ Termination ___ Diag/Asses
___ Individual Supv. ___ Group Supv. ___ Self Analysis ___ Laws/Regs.

Content: _____

Date: _____ Week of: _____

Supervisee _____ Subject of Supervision Session
CMSW # _____ (Mark all that are applicable)
Supervisor _____ ___ Ethics ___ Boundaries
LCSW # _____ ___ Theory ___ Technique
___ Termination ___ Diag/Asses
___ Individual Supv. ___ Group Supv. ___ Self Analysis ___ Laws/Regs.

Content: _____

Supervisee _____ Subject of Supervision Session
CMSW # _____ (Mark all that are applicable)
Supervisor _____ ___ Ethics ___ Boundaries
LCSW # _____ ___ Theory ___ Technique
___ Termination ___ Diag/Asses
___ Individual Supv. ___ Group Supv. ___ Self Analysis ___ Laws/Regs.

Content: _____

	Ind.	Group	Clinical	
Total (this page)				

JW/G5010232/SW

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY
PRACTITIONER
PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWARD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health.

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider to</u>:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records</u>.**

✓CHECKLIST

Before you mail your questionnaire:

Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER:_____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(____)_____ **(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.
1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:
1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name _____ **License #** _____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name _____ **License #** _____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date: _____

(Signature of Provider)
YB/G6019027/RTK-ms.70